SOCIOCULTURAL SUPPORT SYSTEMS OF ELDERLY MEXICAN-AMERICANS: IMPLICATIONS FOR HEALTH AND TRANSCULTURAL NURSING CARE

by

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ABSTRACT

This paper considers the sociocultural support system of 20 elderly Mexican-American people. The purpose of the research was to describe the properties of the sociocultural support system according to the structural availability and opportunity for support and the interactional or supportive bonds within the support system. Also considered was the effect of the support system on health and health care as well as transcultural nursing care implications in relation to the elderly Mexican-American and his support system.

It was found that the informants' supportive contacts were formed on the basis of proximity, kinship and ritual kinship ties, long-standing friendships, and church affiliation. Their supportive interactions consisted of (1) positive interpersonal exchanges, (2) intimacy, (3) self-care through interactions with others, (4) shared norms and experiences, (4) rituals, and (6) instrumental support. The support system appeared to have a positive effect on health and care in several interrelated ways, including (1) provision of group membership and ongoing stimulating relationships that entail significant physical and social activity that could help to eliminate depression, (2) access to a structure where useful role activities are available, (3) provision of economic and health care interventions that decrease need for institutional care, and (4) an emphasis on values

reflecting interdependence and sharing of material and social resources especially among family members.

Collaboration between the professional health care system and the sociocultural support system was discussed and encouraged as a way to provide more effective and culturally appropriate health care.

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CHAPTER I

INTRODUCTION

Purpose

The purpose of this research was to describe the properties and function of the sociocultural support systems of the elderly Mexican-American as related to health care with transcultural nursing implications. The focus was the following:

1. What are the structural and interactional properties of the support systems of the elderly Mexican-American?
2. What is the function of the support system in the health care of elderly Mexican-Americans?
3. What are the familiar and recurrent social elements of the elderly Mexican-Americans' support system that could be integrated into nursing care to provide culture-specific care?
4. What are transcultural nursing care implications for the elderly Mexican-Americans and their sociocultural support systems?

The Problem

Traditionally, it seems that our nursing practices have been restricted to the belief that states of health or illness require a

focus upon the individual rather than an emphasis upon the individual as part of his sociocultural system. As a result, organization of care has largely been directed toward the individual with limited attention to his support group. While individual care is an important part of nursing practice, nursing must also consider participation in care of the individual within the broader context of his social structure, particularly with attention to the arrangement of social relationships in which the individual is a part. It is within these social relationships that it was predicted that the nurse finds features and behaviors forming a system that can help to provide culture-specific care for people in states of health and illness and can also provide clues from which to creatively develop and synthesize nursing care.

This perspective is especially relevant for transcultural nursing, defined by Leininger (1978) as that:

> . . . which focuses upon the comparative study and analysis of different cultures and subcultures with respect to nursing and health-illness caring practices, beliefs and values . . . and takes into account individual and group caring behaviors, beliefs and values based upon their cultural needs in order to provide effective satisfying nursing care to people. (p. 38)

This definition recognizes a caring system inherent in a given culture and it also includes both individual and larger social units as an apposite focus for nursing. Leininger (1978) pointed out that practically all cultures have persons in curing and caring roles as well as a core of supporters. To develop transcultural nursing care that is effective and sensitive to the needs and desires of people, nurse researchers need to focus upon investigation of sociocultural units that give rise to unexplicated caring systems so that those systems can be

used, maintained, and integrated by the nurse in the nursing care. With reference to this, an important role of the transcultural nurse is to use such research findings to care for clients by acting as one member of a group participating in the care of a person and complementing other caregivers.

Henry (1958) wrote that an important function of social structure is to provide everyone with a group of people who can be relied on for support. He implied that this supportive group is a factor in fostering feelings of security and suggested that the better we understand the characteristics of this group, the closer we will come to understanding societies and the functioning of people within them.

Closely related to the concept of support is caring which Leininger (1978) refered to as the:

> . . . direct (or indirect) nurturant and skillful activities, processes, and decisions related to assisting people in such a manner that reflects behavioral attributes which are empathetic, supportive, compassionate, and otherwise dependent upon the needs, problems, values and goals of the individual or group being assisted. (p. 489)

It would seem that Henry (1958) also recognized support as inherent in a caring system, and that it possibly is built upon culturally-based supportive group relations.

One way to investigate support as inherent in a caring system is to use the theoretical concept of support systems as differentiated by Gardner (1977). The latter viewed support systems as goal-directed systems with specific expressions of care that encompass behaviors that strengthen the self-caring behaviors of people. Using the concept of sociocultural support as a framework and some operational terms from

network theory, the present investigation explored the support systems of a group of older Mexican-Americans.

In considering nursing care of the elderly, Leininger (1977) asserted that nursing must take seriously people's needs for social and culturally-based support systems. Further, she wrote that research and theories concerning the role, function, and nature of support systems are needed in the health field, especially in nursing, as the nurse could be a key link in patients' support systems. Because of various social, cultural, and regional differences, it seems that subpopulations of older Americans are an important focus for study. Older Mexican-Americans represent one important cultural group that has received little direct research attention. Exploration of their support systems as an inherent caring system should provide potential data that could be developed to provide culturally-specific care for them.

With research of Mexican-Americans' support systems, insight may be gained into the social and culturally-based relationships that enable the older Mexican-American to move through transitional states, resolve life crises, and remain active members of their family and community. Potential resources such as kin, ritual kin, friends, neighbors, church, informal health caregivers, and other community elements that appear to be part of the sociocultural support system, should be recognized. These potential resources which may exist, but operate apart from and parallel to formally organized nursing practice and appear to have relevance in providing culturally-specific nursing care, could then be included by professional nurses. Inclusion of these elements would entail nursing care that reaches beyond care of the

individual to care for a person within his support system. Caring for the Mexican-American patient and his support system, it seems, would bring about an increased awareness of the arrangement of social relationships surrounding the patient and enable nursing care that is relevant to the issues, problems, and values of the patient within his social structure. As a professional caregiver, the nurse could have a variety of roles in relation to the support system, offering consultation and advice, mobilizing the energies and resources within the system when intervention seems necessary, fostering and encouraging and learning from the good works of other caregivers, working directly with the patient and other members and at times working with a patient indirectly through others in the support system.

Background Concepts and Definitions

As the literature suggests, sociocultural support is a broad concept made up of several components. For this investigation, the following constructs were used to define sociocultural support:

1. Caring: A positive and helpful way of assisting others which reflects concern and respect and provides feedback that encourages self-esteem and self-help and is dependent upon the needs, values, and goals of the person.

2. Sociocultural integration: A sense of belonging to a group, sharing experiences, having common beliefs and values, and knowing there are others who will come to one's aid in time of need.

3. Instrumental behavior: Receiving material aid from

others.

4. Reciprocity: Exchange of supportive behavior back and forth between individuals.

Drawing from these definitions, supportive interactions were found when the individual reported (1) that he had a caring, supportive relationship with another person or group through activities that expressed concern and respect and enhanced his self-esteem and his ability for self-help; (2) that he could depend on the person or group in times of distress for financial help, help with tasks, and help when ill; (3) that he could confide in the person or group, discuss problems and share experiences, and/or share a similar outlook and beliefs; and (4) that, according to him, there was a mutual exchange of other supportive interactions.

Sociocultural arrangements that are reflective of the above supportive behaviors and linked together to maintain health and caring practices by helping people through life's crises and transitions during times of health and illness, can be referred to as sociocultural support systems.

The support system is a network of relationships characterized by social and cultural factors wherein support is available and serves a beneficial or protective function that aids individuals in their adaptations to the sociocultural environment (Dressler, 1980). Caplan (1974) has emphasized the health-protective functions of these relationships and described the support system as an

. . . enduring pattern of continuous or intermittent

> ties that play a significant part in maintaining the psychological and physical integrity of the individual over time. (p. 7)

A sociocultural support system can be viewed structurally as a first-order star social network. The network is only a structural concept that carries no implication for supportive function, however, it does offer a framework in which to study the variables that constitute an opportunity for support (Kaplan et al., 1977). First-order star networks include the direct links radiating from a particular Ego to other individuals and groups, Ego's first-order contacts (Barnes, 1972). Analysis of this portion of a social network begins with selection of an individual (Ego) and identifying other members with whom he is directly linked and then examining the social bonds between him and these contacts (Barnes, 1972). The bonds of interest to this author were supportive interactions; however, all links in a star may or may not be supportive. Similar to the definition used by Garrison (1978), the support system included the constellation of supportive persons or groups plus other direct contacts which may not be identified as supportive.

Sociocultural support, as defined above, and the support system concept were used to consider the interactional properties within the structure. The structural dimensions of the support system included: (1) number of direct contacts, (2) frequency of interaction, (3) directedness of the interaction, and (4) the social elements comprising the contacts.

From a structural perspective, it is suggested that the more

contacts there are and the more frequent the interaction, the greater the opportunity there will be for support (Mitchell, 1969). In another sense, the number of contacts and frequency is a measure of social integration which also implies support. In this investigation, the number of first-order contacts included all habitual contacts established through face-to-face interactions and frequency was the number of times these interactions could be counted over a specific period of time.

Directedness refers to the amount of reciprocity and the direction of the flow of support (Kaplan et al., 1977). This is measured according to Ego's perception of whether or not he in some way supports those who support him. Conceptually, reciprocity is important in that it implies a mutual satisfaction in the relationship and is a factor in the continuance of supportive interactions (Dimond, 1978).

The social elements refer to the participants comprising the contacts. The elements can include kin, ritual kin, friends, work associates, religious associates, other local informed caregivers, and formally organized services directed by professional caregivers (Baker, 1977; Caplan, 1974; Garrison, 1978). Natural or spontaneous elements, those contacts other than with formally organized professional caregivers, were of special interest. These contacts may be the culturally relevant caregiving elements working parallel to nursing practice that could be integrated into the health care provided to older Mexican-Americans.

CHAPTER II

LITERATURE REVIEW

Professional Health Care and Support Systems

In recent times, there has been an attempt to broaden the conception of health and illness and the focus of care to include not only the individual, but also the sociocultural factors surrounding him (Dreitzel, 1971). Dreitzel (1971) contended that a restructuring of health care is need to accommodate the patient within the context of his social relationships and sociocultural environment. Likewise, Aamodt (1978, p. 41) recognized that American health-care practices have been characterized by one-to-one interpersonal interactions such as the nurse-patient and physician-patient dyads. She stated that this emphasis on one-to-one interactions is gradually being supplemented with a recognition of the network of individuals that form what she called the 'personal community' or multiple caretaking system of a given member of society. She stressed the importance of research and documentation of this caretaking system to: (1) determine who, within the social structure, is available to give support and counsel; (2) learn about caring roles for a given cultural system; and (3) consider who should be included in the organization of a health care delivery system (Aamodt, 1978, pp. 41-42).

Baker (1977) also pointed out the growing recognition among professional caregivers of the existence and importance of caretaking

systems that operate outside of the established professional caregiving system. He referred to this alternative system as a natural support system which can include family and friendship groups, mutual help groups, local informal caregivers, and voluntary service groups not directed by caregiving professionals (Baker, 1977, p. 139). He suggested that as we strive to develop more comprehensive integrated models of service delivery, this support system should be considered. Further, he believed that the two systems could complement each other by exchanging resources such as information, people, materials, and financial resources (Baker, 1977). Dimsdale (1979), too, emphasized the value of establishing creative interactions between the professional and nonprofessional caregivers saying that attention to resources outside the professional health care system may well affect the efficacy of care provided by medical professionals.

In reference to offering professional nursing care to diverse cultural groups, Leininger (1978) stressed the importance of assuming a participatory role and actively involving the cultural group's representatives in the conceptualization and implementation of health activities. Direct involvement of community members in health activities, it seems, will help to bring about health care that is reflective of the culture's values, social structure, and caring practices, and thus, more acceptable and appropriate for them.

In summary, all have emphasized the importance of study and identification of supportive elements within the support system, especially those that are culturally-based and spontaneously-arising and those that are organized by nonprofessionals, so that these supports

can be fostered, stimulated, and integrated into professional health care in a way that does not distort or inhibit them.

Support in Relation to Health

There is a large volume of research dealing with support in relation to disease susceptibility, stress, crisis events, psychosocial development, and life transitions. The availability of support as part of the sociocultural environment has been viewed as being a protective factor that determines to some extent a person's susceptibility to physiochemical disease agents. It is not seen as having a direct effect on health, but as a factor in modifying stress and strengthening the individual's coping efforts. Support may also be a crucial dimension of normal physiological and psychosocial development, especially with regard to infants and children.

The absence of social support has been implicated in the genesis of some diseases (Kaplan et al., 1977); for example, people who, for various reasons, had no intimate group to relate to were found to have higher frequencies of tuberculosis. deAraugo (1973) found that chronic asthmatics who had few supporters needed more medication than others. VanHeijningen (1966) observed that rejection by a loved one frequently preceded the onset of coronary disease.

There is evidence that insufficient stimuli in the form of maternal love and support is associated with retarded growth and other physical and behavioral abnormalities in the infant and young child (Kiritz & Moos, 1974).

Recent work by Wells (cited by Dimsdale et al., 1979) correlated

psychosomatic symptoms, stress, and social support, and showed that ulcers, angina, and neurotic symptoms associated with occupational stress were lessened in the presence of social support. Nuckells (1972) found that social support, when considered with stress, was significantly and inversely related to the frequency of complications during pregnancy. A study of social support, stressful life events, and psychiatric illness of a Chinese-American population indicated that social support contributed significantly to illness symptoms with the social support measure being much more significantly (and negatively) related to the symptoms than the stressors (Lin, 1979).

While investigating individual responses during crisis situations, Caplan (1974) found that the outcome of the crises was influenced not only by the nature and difficulty of the stress and the current ego strength of the individual, but most importantly, by the emotional support and task-oriented assistance provided by the social network within which the individual struggled with the crisis event.

The social network, as a support system, has been shown to have a preventative and curative role in the community for formerly hospitalized schizophrenic patients (Sokalowsky, 1978) and the presence of support with a confiding reciprocal relationship between the confidant and patient previously hospitalized for a depressive illness was found to have significant protective qualities against recurrence of symptoms (Surtees, 1980).

The social network, as a structure for social and cultural integration, has seemed important in protecting people as they grow older. In explorations of aging, Blau (1973) and Lowenthal and Haven

(1968) reported that high social interaction, which implies high stimulation and activity, is protective against depression.

In summary, though the mechanics are not as yet fully understood, it appears that support systems may have significant health-related effects in a wide variety of life transitions, crises, and potentially pathologic states.

The Concept and Use of Social Network Analysis

The term "social network" refers to the interpersonal linkages among a set of defined individuals and has been used in an analytical sense to understand the behavior of people by investigating the characteristics of their social linkages or networks rather than focusing on the attributes of the people themselves (Mueller, 1980). Network analysis has been applied to a variety of social phenomena.

Bott (1971) explored the connection between the conjugal roles (the division of labor between husband and wife in the home) held by married couples and the pattern of social relations among them and their friends. Barnes (1954) attempted to explain social behavior in a Norwegian island parish by researching the patterns of linkages among the parishioners. Boswell (1971) used a network containing institutionalized links between a social welfare worker and a hospital administrator, links between individuals as fellow members of a religious organization, and links deriving from common tribal membership in his analysis of how a crisis was resolved. Mayer (1966) used network linkage to examine how a politician tried to get votes for himself in an election by mobilizing the support of his first-order contacts, who,

in turn, sought support from their contacts, and so on until as many voters as possible had been reached. Coleman (1966) used network techniques to study the acceptance of new drugs by a community of physicians. They found that physicians usually made the decision to switch to the use of the new drug because of some interpersonal relation. In the first steps, these relations were with medical advisors or discussion partners. Later, other physicians adopted the drug because physician friends had already done so. Briefly, network analysis has also been used to understand the adaptation of migrants (Mayer, 1962), the utilization of health services (McKinley, 1972), and the social relationships of psychiatric patients (Pattison, 1975). Thus, the use of network analysis is not tied to any particular theory but can be used to examine diverse views of social action.

Data from network construction are usually collected through observation and responses to interviews and questionnaires. There are many techniques of analysis that can be applied ranging from simple discussion of first-order stars (as this author did) to use of mathematical tools derived from a branch of mathematical topology known as graph theory.

The Content of Support Systems

Supportive interactions have been conceptualized by Caplan (1974) as enduring or intermittent relationships that help an individual deal with the general issues of life and provide assistance during acute need by aiding him to mobilize his psychological resources and master his emotional burdens; sharing his tasks; and providing him with

extra money, materials, tools, skills, and cognitive guidance to improve handling of his situation.

In a more restricted sense, Cobb (1976) has viewed information as the concept central to support saying that support is information that leads one to believe he is cared for and loved, esteemed, and belongs to a network of communication and mutual obligation. From a different perspective, Weiss (1974) defined supportive interactions as relationships that provide for attachment, social integration, nurturance, reassurance, alliance, and guidance.

These definitions suggest several dimensions of support, all of which overlap. Dimond (1978) brought together several viewpoints concerning support and concluded that social support involves communication of positive affect and caring, social integration, instrumental behavior, and reciprocity. These dimensions provide a clear framework for use in identifying socially supportive interactions.

The social units forming support systems are derived from diverse sources and are initiated and maintained for a variety of reasons.

> . . . people have a variety of specific needs that demand satisfaction through enduring interpersonal relationships such as love and affection, for intimacy that provides freedom to express feelings easily and unself-consciously, for validation of personal identity and worth, for satisfaction of nurturance and dependency, for help with tasks and for support. To meet these needs people involve themselves in a range of relationships such as: marriage, parenthood, other forms of loving and intimate ties, friendships, relationships with colleagues at work, membership in religious congregations and social, cultural, political, and recreational associations and acquaintances with neighbors, shopkeepers and providers of services and help-seeking relationships with professional caregivers. (Caplan, 1974, p. 5)

Often, an individual's supportive caretakers are those who live and work

nearby and have come to be known and respected, show empathy, sensitivity, and understanding; share similar experiences and problems; share similar beliefs and values; are bound together by reciprocal obligations; or finally, are caregiving professionals (Caplan, 1974).

Cobb (1975) asserted that supportive interactions began in utero. Speaking of the Anglo-American culture, he continued, that as life progresses support is derived increasingly from other members of the family, then from others in the community and later life, once again derived mostly from family members.

Discussing likely participants in support systems of the elderly, Lopata (1975) contended that in less complex societies, support systems most often grow out of primary relations, ascribed automatically at birth and replaceable upon loss from a relatively small group of familars. Whereas, in complex industrialized societies there is more dependence upon secondary supportive relationships which are less personal, formalized, and organized around specific functions. She suggested that the elderly in urban America, because of the society's complexity, need the ability to engage in secondary sources of support. However, in the presence of highly specialized and segmented social institutions, characteristic of complex societies, which might only provide diffuse support, the family may be vitally important as a source of enduring ties that provide for more continuous support.

In a study of American urban elderly Anglos, Blacks, and Puerto Ricans, Canto (1975) found that their support systems involved family, significant others, and government and voluntary organizations. Similarly, working with Mexican-American elderly, Crouch (1972) noted that

family, church, and government agencies were all perceived to be obligated to help.

The structure of an individual's support system as caregivers emerge and are available to give support is influenced by the individuals' biosocial needs. The structure of the support system is also a response to the values and traditions operating within the culture (Caplan, 1974) and further, it is shaped by the social structure (Aamodt, 1978; Henry, 1958). For example, among the Hopi of the American Southwest, matrilineal ties and the maternal household made up the core of a man's supportive group (Henry, 1958). In contrast, among the Pilage of Argentina where there were great food exchanges, a man's supportive group was made up of those with whom he exchanged food most often and those who lived with him longest, regardless of kinship (Henry, 1958). For the poor urban-American Black person, the support system is likely to consist of a fluid group of kin and nonkin who are linked by reciprocal and obligatory swapping of goods and services to form a domestic network which is a nucleus of familial, social, and economic cooperation that provides a group identity and steady source of support (Stack, 1974; Osborn, 1977).

Another example is the situation of a typical Anglo-American child who has relatively few supportive contacts (Henry, 1958) compared to the Mexican-American child who may be able to secure more supports through the compadrazgo (ritual parenthood) relationship and the Papago Indian child who has several caregivers by way of his extended family arrangement (Aamodt, 1978). In summary, the individual's needs, the cultural prescriptions for behavior, the social structure and the roles

assumed together influence who provides supportive interactions within the support system.

To learn from a transcultural perspective more about who cares for older people, how they adjust to aging through the use of supports, and how they are maintained at home and in the community, one important factor to consider is their support systems (Benavidez-Clayton, 1977; Leininger, 1977; Shimamato, 1977). If, as Benevidez-Clayton (1977) urged, we are to develop nursing care for older people that acknowledges and is adaptive to these supportive elements, it seems necessary to study in depth the support systems of elderly subcultural populations.

Sociocultural Relationships of Older Mexican-Americans

Mexican-Americans (people of Mexican descent born either in Mexico or the United States) represent the second largest minority in this country (Benavidez-Clayton, 1977), and Utah's largest minority (Mayer, 1976). They are a diverse group that has not uniformly acculturated to the ways of the dominant Anglo culture, nor have they been as fully assimilated as other minority immigrant groups (Burma, 1970). The proximity of Mexico and the geographic oneness of the United States' Southwest with Northern Mexico has complicated acculturation and assimilation. Migration in both directions has remained extensive, thus cultural and familial ties have not been broken (Wagner & Haug, 1971). The group is fragmented socially, ideologically, and organizationally and is characterized by social class, regional, and rural-urban differences (Penlosa, 1970). Nevertheless, there is a growing

sense of Mexican-American self-identity (Penalosa, 1970) and a sense of fellowship (Forbes, 1970). Generalizations have been based upon characteristics that many Mexican-Americans, including those in Utah, are likely to share.

It is said that for many Mexican-Americans, the family is considered very important (Crampton, 1967); however, there may be a departure from traditional norms especially in the urban setting. Kinship is reckoned bilaterally and at times, the extended family pattern is retained (Burma, 1970). Such a family unit is comprised of parents, siblings, parents' siblings (especially mothers' sisters), grandparents, and first cousins (Rubel, 1970). Kinship terminology pointedly distinguishes these from other classes of relatives (Rubel, 1970). The relationship among sisters and their mothers is important and persists through the life cycle. Bonds are perpetuated through frequent visiting even when there is separation by marriage and geographical distance (Rubel, 1970). The kinship structure can be a supportive and flexible structure which assumes functions in dealing with the environment and with the emotional and psychological aspects of the family unit and individuals, providing care for children and social support for adult and aged members (Crampton, 1967; Maldonada, 1979). Crampton (1967) found Mexican-American family ties in Utah to be close and characterized by an extended family structure.

In many regions, the ritual kinship relation comadrazgo, a term which designates the particular complex of relationships set up between individuals primarily, though not always, through participation in the ritual of Catholic baptism (Crampton, 1967) remains a significant

relationship which leads to close ties between people (Penalosa, 1970). The compadre system has evolved into a ritual kinship practice that is supportive and meaningful to many Mexican-Americans. Help and assistance is supposed to be forthcoming and often comes from godparents, and a reciprocal relationship between parents and godparents helps promote social solidarity (Crampton, 1967). Also, there are groups of male associates, palomillas, organized around frequent social activity. The palomilla signifies a close-knit group which is based on mutual likes, dislikes, local, and usually social class ties (Crampton, 1967).

Rubel (1970) reported that Mexican-American neighborhoods may be atomistic in nature with each household often standing alone. It is said that often, those who pay social calls to a household are persons whose range of conduct is quite circumscribed. They are likely to be either close kin or related through ritual kinship (Rubel, 1970). Further, it is said that where neighborhood and family relations are concerned, the family is the unit wherein most material and social needs are expected to be fulfilled (Rubel, 1960).

Mexican-Americans have predominantly affiliated with the Catholic religion, the traditional faith of Mexico. Among the Utah Mexican-Americans there is also a preponderance of Catholics (Crampton, 1967). The Catholic religion has played a part in fostering a sense of fellowship and social integration by providing a social nexus and also providing a tie with the Mexican past (Sumner, 1970).

Poverty has been a long-term problem for the majority of Mexican-Americans. Immigrants come with a language handicap, illiteracy, and lack of training in skills saleable in the United States and are,

therefore, unable to function to full capacity in an alien culture. As a result of these conditions and discrimination, they have been forced into the lower paying jobs (Burma, 1970). Few of Utah's Mexican-Americans are involved in professional and business groups, most occupy skilled and unskilled labor jobs (Crampton, 1967). Also among Utah Mexican-Americans, school dropout rate is relatively high (Crampton, 1967). Increasingly, Mexican-Americans, especially of the second, third, and more generations, are finding industrial and professional employment (Burma, 1970). However, relationships formed through contacts on the job and also at school are often of an impersonal type, especially when the relationships cross ethnic lines (Sumner, 1970).

Illness is frequently a matter of concern for the extended family. Often, no member of a family is regarded as ill unless the head of the family approves. Hence, an authoritarian relationship assumed by the physician or nurse with the Mexican-American patient is often inappropriate and resented. In caring for a Mexican-American patient, a health worker is not dealing with a single individual but with an extended family which often includes distant relatives and <u>compadres</u> (Madsen, 1970). As Leininger (1978) pointed out, understanding the network of informal and largely kin-based relationships that provide physical security, emotional support, and social obligatory bonds in the Mexican-American community is an essential consideration for nurses. The Mexican-American style of living necessitates that the nurse learn to function as a participant member in a helping community.

Within the home it is the women who bear the major responsibility for the family's health (Kay, 1979). When an illness does not

respond to home care, outside help is sought perhaps first from a neighbor or compadre, then from a curandero (folk curer), or professional health caregiver (Madsen, 1970). In Utah, curanderismo (folk healing), especially among lower income people, is a continuing practice that compliments professional health care. The expense of professional medical care, language barriers, attitudes of doctors and nurses, and the strange environment of hospitals and clinics keep many Mexican-Americans loyal to their folk healers (Mayer, 1976).

At present, there is not much information concerning the social relations, availability of support, or the medical care of older Mexican-Americans. The literature that is available reveals conflicting views. Some depict the elderly as highly respected and integrated members of the family and community, while others present an image of them as a lonesome group with poor neighborhood relations and lessening family support.

For example, Clark (1970) identified the supportive attitude of the Mexican-American family towards the aged by quoting an informant:

> When a person gets old and has to have someone to take care of him it is better for him to be at home with his family than in a hospital among strangers. When someone gets old he may act a little crazy and he needs his family with him to understand him and help him. In a hospital he would feel worse because he would think everyone deserted him. (p. 145)

Similarly, in an investigation of older Mexican-Americans, Carp (1968) reported that children prefer to care and provide for their elderly parents.

In contrast, from the U.S. Senate Committee on Aging, comes a very different view:

> In addition to the economic difficulties which are encountered by the Mexican-American elderly, they find themselves in a world apart. They get sick rather easily, they lack good neighborhood relationships and their thinking is very different. They have difficulty getting their food and medical care because of distance and ambulatory problems. They feel themselves an imposition on relatives and friends if they ask for any kind of help. (Moore, 1971, p. 33)

Authors report that the family pattern is gradually being transformed from the extended family to nuclear family organization (Crouch, 1972; Maldanado, 1979; Moore, 1971) with an attendant lessening of family ties sustained through shared work, income and social visiting, and a devaluation of the roles of the aged (Benavidez-Clayton, 1977). Nevertheless, a recent researcher, focusing on one state of the Southwest with a large Mexican-American population, reported that even today, Mexican-American families are twice as likely as the population as a whole to exhibit multigenerational structures; further, it was noted that there are few Mexican-Americans of any age living alone (Eribes, 1978). Thus, it seems that the older Mexican-American is likely to be living in a household with at least some family members.

There may, however, be a lessening of dependence of the elderly upon their families as their sole source of support. It is reported that a significant proportion of the elderly do not expect economic aid from their families, instead, they are anticipating more help from the church and government (Crouch, 1972; Cuellar, 1980). Also in the community, there are emergent voluntary associations forming around senior citizen organizations that are providing a social unit in which members can share experiences and information, gain a new perspective, and acquire new roles (Cuellar, 1980).

Benavidez-Clayton (1977) pointed out that one of the few things we know about the lives of Mexican-American elderly is that they are not in nursing homes. In research of the underutilization of nursing homes by Mexican-American elderly, Eribes (1978) concluded that the lack of use is not due to economic unfeasibility or inaccessibility (the data suggest that if family incomes were increased they would utilize nursing homes less than they do now), but instead, to culturally defined practices and values wherein families, viewing nursing homes as alternatives of last resort, try to keep their elderly out of institutional facilities. Considering this and the pattern of sociocultural relationships described in general for the Mexican-American, there may be culturally-based elements within their support systems that operate to provide care and maintain the health and integrity of the older person. These are supportive elements that should be acknowledged by the nursing profession so that new creative interactions between nurses, patients, and their supportive caregivers can be formed.

CHAPTER III

RESEARCH DESIGN AND METHODOLOGY

The general research approach utilized was a descriptive survey that explored the sociocultural support systems of elderly Mexican-American people. Included is a description of the structural and interactional properties of the support systems, investigation of the role of the sociocultural supports as they relate to health care, and consideration of transcultural nursing care implications related to elderly Mexican-Americans and their sociocultural support system.

The Population

The Mexican-Americans of Utah represent the state's largest non-European ethnic minority. The group is composed of those who have emigrated from Mexico and those of Mexican descent who were born in this state or elsewhere in the country. Those in the sample were individuals 60 years of age and older who were living in their homes in a small city in Northern Utah. They were bilingual, speaking both English and Spanish.

The sample included 20 men and women chosen randomly from a list of persons who had identified themselves as 60 years old or older and of Mexican descent during a door-to-door census of the community that was recently completed as part of another research project.

For the purpose of this research, persons who identified

themselves as having a Mexican heritage when approached during an initial visit were assumed to be Mexican-Americans. Sixty years and older seemed an appropriate age group. Research has shown that Mexican-Americans have a proclivity to perceive old age to begin at or below 60 (Crouch, 1972).

Method of Data Collection

Potential informants were initially approached by visiting their homes. The project was explained to them at that time. When consent for participation was obtained, times for further meetings were arranged. The data were collected through use of an open-ended interview guide (see Appendix) conducted during three to four visits to the informants' homes. Notes containing direct quotes and summaries of conversations were taken during the interviews. The notes were later recorded in a journal that contained direct quotes, an expanded account of the interview, and the investigator's subjective impressions.

Description of the Interview

The interview guide was devised to answer questions that have been postulated with respect to the elderly Mexican-Americans' sociocultural support systems. It is recognized that since there are no available known questionnaires or interview schedules which have been tested previously for reliability, the interview used in this study was of face reliability and composed of items viewed as relevant to the cultural group. These items also included pertinent queries related to the sociocultural support systems as they pertain to care of elderly Mexican-Americans.

The interview was designed to elicit all repeated social contacts, those "first order" contacts within the network that are established through face-to-face interactions and the supportive interactions, including the function of the supportive elements in providing health care that took place within the first order network.

This was approached in several overlapping ways. The informants were asked to identify as many contacts as possible: kin (as they were designated by the informants' terminology), and nonkin who were residents in the household; kin outside the household whom they visited; neighbors in the building or on the block; friends and acquaintances and how they came to know them; coworkers, if employed; religious associates; formal and informal group participations and contact with formally organized agencies such as professional health care and social service agencies. The contacts made during the informants' spare time along with recreational and holiday activities and other special events such as weddings and funerals, were also elicited. The frequency of interactions were determined by asking if they took place on a daily, weekly, monthly basis, or less often. The number of different contacts comprising the network could then be totaled.

Information was obtained about the network structural property of directedness, or reciprocity, and the supportive interactions within the network. The informants were asked by whom, from among the persons they talked about, did they feel "cared for," whom did they count on for anything, in whom did they confide, with whom did they feel they shared a common understanding and world view, and to whom from among them did they offer care and help. Specific questions were asked

concerning who provided help with tasks, financial and other material assistance; help when ill or desiring health care measures; and with whom could they confide, discuss problems, and share experiences; and finally, how in other ways people let them know they were cared for.

A reconstructed day was also elicited from each informant in order to learn from another perspective more about the functioning of the support system. The focus was with whom the informants were in contact during the day and what they did for each other. In addition, a detailed account of a recent health problem experienced by the informant was sought to learn about the role of the sociocultural supports in relation to health care. Probes were used concerning where they got most of their health care information, how they cared for themselves, and who helped them stay well; who was of help to them during illness; to whom they went for care; and if care was received from professional caregivers in a clinic or hospital, who accompanied them or visited them; and who, from among family acquaintances, would they want involved in their care.

CHAPTER IV

DATA PRESENTATION AND INTERPRETATION

Structural Properties of the Support System

Analysis of the structural properties of the support system included consideration of (1) the number of first-order contacts; (2) the frequency of the interaction in daily, weekly, or monthly time periods; (3) the social elements comprising the contacts; and (4) the directedness of interaction.

Numbers and Frequency of Interaction

In general, the informants had several and frequent interpersonal contacts. All had at least one daily contact and none seemed to be alone for more than three to four hours daily. The mean number of daily first-order contacts was four. The mode was also four. The mean number of weekly to monthly contacts per informant was seven with a mode of eight and the mean total of first-order contacts was nine. This finding is consistent with the 6 to 10 contacts Hammer (1978) considered to be typical of the intimate portion of networks for persons from general populations.

Social Elements Comprising the Contacts

The only consistent daily contacts for all informants were kin. Table 1 shows the kin types comprising the social contacts and the

Table 1

Kin Types Comprising Social Contacts

Type of Contact	Frequency
Daughter	65%
Grandchildren	65
Spouse	45
Son	45
Godchild	25
Sister	20
Cousin	15
Brother	15

percentage frequency of the type for all informants. The most prevalent types of kin comprising the contacts were daughters and grandchildren followed by spouses and sons, then godchildren, sisters, cousins, and brothers. Godchildren were referred to as kin. Statements such as, "he is just like a relative," or "I treat her like my own child or grandchild," were made to explain the relationship to the godchild.

This pattern of kin contact is reflective of the informants' living arrangements based on the usual composition of their households. Table 2 shows household composition and percentage frequency of household member types for all informants.

Table 2

Household Composition

Informant's Household Member(s)	Frequency
Spouse	35%
Spouse and Daughter	30
Daughter and Grandchildren	10
Son	5
Granddaughter	5
Cousin (Female)	5
Goddaughter	5
Alone	5

With the exception of one informant who lived alone but had neighboring kin, living arrangements were with spouses or in multigenerational households. In the multigenerational household, it was common for the elderly person, man or woman, to live with female kin,

especially daughters.

The frequency of kin interactions was influenced by the sex of the relative with more female relatives more often in contact with their elderly kin. Kin interactions were also associated positively with genealogical closeness and ritual kinship ties. Children and siblings, along with spouses and godchildren, comprised most of the contacts. Geographical propinquity also influenced the frequency of interaction. When relatives lived in the same neighborhood they saw each other many times daily. However, kin who lived in the same town but in different neighborhoods were considered to be quite far away and were seen much less often.

One to three nonkin contacts were seen by most (85%) on a daily to weekly basis. These included friends, neighbors, and church acquaintances. Men had more nonkin contacts than women. Usually, these were friends they had known for many years with whom they stayed in touch by visiting in their neighborhoods and meeting together in informal groups in bars and cafes. Women frequently stated they did not have many friends outside their families and those they had, they had met through their husbands and other male kin. However, they all had at least one friend they saw frequently. Most of their interactions with kin as well as nonkin took place in their homes. Unlike men, women friends did not meet in groups; instead, they formed one-to-one relationships in which they talked, went shopping, and helped each other with tasks.

However, clusters of female kin were formed through mother, daughter, and granddaughter ties wherein there were many daily contacts

and often shared households. Frequently, groups of these women acted together to organize family activities, marking religious and other holidays, birthdays, baptisms, and funerals.

Participation in formally organized groups was limited to varied denominational neighborhood church activities. Gatherings were frequent and a source of much social activity.

There was an expressed awareness of voluntary organizations for the elderly but there was little participation. Several informants stated they did not want to be with people they did not know well, or had no desire to participate because they spent most of their time with families and still had many time-consuming responsibilities at home. Further, they did not have specialized interests, hobbies, or recreational activities outside their homes or away from family members. In general, contacts with the world outside the family, neighborhood, and church seemed brief and impersonal, mediated through local businesses, representatives of various financial and medical service agencies, and mass media in the form of television and both English and Spanish newspapers. Men more than women articulated with the larger society, being more aware and active concerning political matters, spending more time in business places, making appointments for themselves and other family members with medical and social service agencies, and watching the news and reading more.

These findings support those of earlier research (Burma, 1970; Crampton, 1967; Rubel, 1970) that extended kin and ritual kin remain as significant elements within the Mexican-American social network. As Eribes (1978) found, these elderly Mexican-Americans are not

living alone; instead, they live with kin, frequently in multigenerational families.

Also, these results concur with Rubel's (1970) point that the relationship between lineal female kin is persistent and close and, as reflected in the pattern of living arrangements and divergent social activities of the men and women, women may provide the hub of many intrafamilial bonds. The literature (Crampton, 1967; Rubel, 1970) and these findings suggested that there are differences in who comprise men and women's social contacts. Possibly due to differing social roles wherein women's activities were circumscribed and focused in domestic areas and men's activities were directed more to the world outside their homes as well as differing work experiences (the women had worked mostly as housewives and the men as wage laborers), women had a more narrow range of contacts. The sources for their contacts were often kin relations as compared to men whose source of contacts more frequently included nonkin as well as kin relations.

This pattern of social elements comprising the contacts may give a very crude indication of the extent to which these people are assimilated in the larger community. Though according to the numbers and frequency of contacts there seems to be a substantial amount of sociability, their contacts appear limited to kin and one or two long-standing close-friend relationships. They seem to have few ties to the community beyond churches and "one-block" neighborhoods. Perhaps, as suggested by Sumner (1970), other social relationships have been held at an impersonal level.

Directedness

The informants were asked whether they themselves supported other people (particularly families and friends) and whether they gave some kind of help to others. All were able to enumerate ways in which they aided people. About half of the informants reported that they helped with money. Others provided services such as babysitting, household repairs and chores, transportation, and running errands. Many related that they did not always feel generous or want to help, but felt an obligation to make the sacrifices that seemed necessary.

All seemed to see their relationships in their networks as "two-way streets" with no one in the network in an extremely dependent or superordinate position. It was pointed out that these reciprocal relationships could be direct processes between two people or more often an indirect relationship involving a group of people. Explanations such as these were given:

> I do the work around home and take care of my daughter's little ones while my daughter works so we can eat. It's a good trade-off.

> Sometimes when I help somebody in the family he might turn around and help someone else and might get care sometime from someone else. That is how it works. It balances. That is how to get by.

Thus, it seems that these reciprocal relationships not only operate in answer to the demands of symmetrical one-to-one relationships, but according to the obligations and needs within an interdependent cooperative group of people. This pattern of reciprocity may have helped to ensure a sense of security and group identity. It may also have helped to guarantee a flow of economic resources among family members who

frequently do not have adequate financial incomes.

In summary, reciprocal first-order network contacts were characterized by mutual obligation and formed on the basis of proximity, kinship ties, long-standing friendships, and church affiliation. Thus, these people moved about and had contacts within a limited geographical and social space. Unlike Rubel's (1970) report of Mexican-American social relationships, friend and neighborhood relationships were present among these people, especially among the men who formed friendship groups organized around social activities. However, relatives, especially female kin, comprised the largest number of social contacts. Most contact with nonkin as well as kin were highly familiar and personalized and there was little exposure to sources and activities that would provide new contacts.

Interactional Properties of the Support System

Interactional properties refer to the supportive content within the network relations. Examining the data, it appeared that as suggested by the literature, "support" can be viewed as a broad concept having many related components. In an attempt to define the nature of support for this elderly Mexican-American population, the supportive content found within the informants' networks can be described through these categories: (1) positive interpersonal exchanges, (2) intimacy, (3) self-care through interaction with others, (4) shared norms and experiences, (5) rituals, and (6) instrumental support.

Support from positive interpersonal exchanges is the most general category of support and refers to the knowledge that members of

the network can be mobilized and depended upon to fulfill needs. This support involves communication that provides feedback and sanctioning of behavior and clarification of expectations as well as nourishment for self-esteem. The following informants' comments are indicative of such support:

> The biggest blessing in my life is that I can be certain that they [family and friends] will in all ways do the best they can for me, even when they don't have much. By the things they do they show me that I can depend on that. . . .
>
> Sometimes when I start wondering, what am I doing in this world?--I talk to my friend the priest. He lets me know that I'm doing OK and gives me encouragement. To me that is support. . . .
>
> Once in a while when I don't feel good I get cranky with my daughter. She doesn't put up with it though. She lets me know and sets me straight. I appreciate it. . . .
>
> As I get older I worry maybe I will burden my family. By the things they do for me they try to convince me that they don't want to hear about that. I keep busy helping them. They let me know I'm appreciated and that makes me feel good about myself. . . .

Intimacy as a means of support involves the opportunity for a close personal relationship that is marked by emotions of love and affection and allows expression of emotional feelings. The following comments portray the support in an intimate relationship.

> We have been married 53 years. Our life is strong. It is a great help to know I can show him how I feel happy, sad, mad, or whatever. . . .
>
> My daughter's love is my biggest support. . . .

Self-care, as shown by the following statements, concerns support obtained through initiation of interactions with others as well as the confidence gained through knowing that one can provide for one's

self.

> It means a lot to me to always try to help out my children and godchild even now that they're grown. I try to make sure they know they can come to me and I'm grateful when I can do something for them even if it's just giving them my ideas on something. . . .
>
> It does me good to get out with my friend from time to time. I call him and we go out to the bar or some place and laugh and talk. It puts me in good spirits. It's good for a man. People have to make the effort to do that and get out. . . .
>
> A guy from the government came around saying they were going to help us get a new roof. Well, we didn't hear anything more about that help, but we did need one. I figured out how to get it on my own. I'm happy to depend on myself and my family. . . .

Support from shared norms and experiences as indicated in the following comments comes through a sense of belonging and group solidarity and the comfort of consensus and familarity.

> When I am with my Mexican relatives I feel like a complete person. We do have some fights but we can understand each other. My friends are gone but it is good to know I have someone that still knows me. . . .
>
> The biggest support is to know someone is "behind you" and agrees with you and can understand. . . .
>
> We grew up together. We married and had children. Now we are old and single but we know each other's lives and we can talk. . . .

Different rituals were identified by the informants as supportive. They included religious and health care rituals and other social rituals. The supportive meanings attached to some of these rituals were described as follows:

> To me prayer is a precious thing that sustains me, even during the hardest times. . . .

> When someone in the family is sick I often light a candle and pray to my patron saint. That is an ever present comfort. . . .
>
> Every Sunday I have a big family dinner at my house. We haven't missed one for years. By having them here I can get them all together. Otherwise they wouldn't see each other so often--and it's a way that I can do something for them. . . .

Instrumental support, illustrated in the following comments, includes the tangible aspects of support, the exchange of material goods and services, and also the knowledge that various items and help are available if needed.

> I don't have any retirement or Social Security income. My daughter has me stay here with her. I can't see well enough to cook. Without her the doctor or government might try to put me in a nursing home. . . .
>
> For the most part, I am financially independent and I can help my children out with money when they need it but if I need anything done around here--like when the furnace went out--I know I can count on them to help. . . .

Most informants indicated that they felt their supportive needs were met. However, two informants made several statements relating their dissatisfaction with the amount of general and intimate support they received. Statements such as "quite often I think that I don't get all that should be coming to me. . . ." and, "maybe I'm demanding but maybe I need more love and help than others to be happy. . . ." were made to illustrate their points. Both of these informants had above-average numbers and frequency of contacts. They also had spouses and children whom they felt loved them, yet they did not feel as completely gratified as other informants. This finding could be interpreted to mean that people have different levels at which their

supportive needs are satisfied. In this study, the dimension of personal needs vis-a-vis satisfaction or the perception of "needs fulfillment" was not fully investigated. It seems that further study of the mechanisms of support should include this dimension.

Considering the diversity of views surrounding the nature of support as well as the likelihood that cultural variability is considered to be supportive behavior, it seems evident that while 'support' cannot be measured in undefined terms, few a priori assumptions can be made in investigating the concept. Thus, the interview guide used was structured in an attempt to set guidelines for defining support and also accommodate the informants' view of support.

For these people, instrumental behavior or the tangible aspects of support such as the exchange of material goods and the help to accomplish tasks seemed to be a part of their supportive interactions. There is disagreement in the literature about instrumental behavior as a component of support (Dimond, 1978); however, it was an important part of these elderly Mexican-Americans' supportive interactions perhaps because they sometimes had physical limitations in what they could do for themselves, and they frequently had limited financial resources that were shared among a group of people.

Another kind of supportive interaction evident in the findings was the way these people cared for themselves by actively initiating contacts with others in order to gain a sense of purpose and well-being and a chance to assert themselves. This is a strategy in which support is given to oneself through interactions with others. These elderly may be using this strategy to effect a continuity of social role

allocations and self-identification. This is a category of support that deserves further explication, especially in investigations concerned with support mechanisms and adaptation to changing social positions as a part of the aging process.

The support transmitted from intimate dyadic relationships was clearly expressed by the informants. These relationships involved a mutual trust where emotions could be expressed. As Cobb (1976) noted in his discussion of support and intimate relationships, such relationships between two people may help to meet needs of succorance, nurturance, and affiliation. This is the support that is often called emotional support or caring (Cobb, 1976).

The aspect of social integration seemed to be a part of several categories of support. It seemed supportive for these people to belong to a system of mutual obligation where they could be useful. They sought ways to help and fulfill some necessary function. Dimond (1978) pointed out that this in itself is supportive, explaining that in situations where a person is sometimes dependent on others, the opportunity for the dependent one to perform a useful function could meet the requirements of reciprocity and at the same time increase the person's self-esteem and sense of competence. It was also supportive to have a sense of shared norms and experiences and to know that one's general life situation could be understood and appraised from a shared viewpoint.

Rituals also provided a means of social integration wherein relatives were brought together to share a meal and maintain ties. Rituals were also used as personal consolation during hard times and

used with the intention of helping someone such as a sick person.

In summary, the structural opportunities and interactional mechanisms for support indicated that these elderly Mexican-Americans, for the most part, had reciprocal and highly personal networks comprised of friends and family on whom they called for assistance. Their support networks provided a set of social relations in which love, self-validation, increased self-esteem, and self-identification could be obtained and where self-disclosure was allowed and ideologies and life experiences were shared and appreciated.

The above information has focused primarily on the generalized functions of the network in providing support. Now, discussion will be directed more specifically to the function of the support system as it relates to the health care of these people and to the current social elements within the support systems that could be integrated into nursing care.

Role of the Support System in Health Care

Supportive persons including friends, religious leaders, and kin (especially daughters), were seen by the informants as important contributors to their health care and it appeared that members of the support system favorably influenced health and health care through several different mechanisms.

The most pervasive way in which the support system seemed to influence health was through provision of ongoing meaningful personal relationships, where self-identity was intimately tied to group membership, and a stimulating environment which allowed the older person

to engage in a significant amount of physical and social activity and thereby mitigate passivity, day-to-day sameness and resultant disorientation, depression, and other mental impairment that could imitate dementia or chronic brain syndrome. All informants, in one way or another, described this health benefit. The following statements are examples:

> Being with my husband and family keeps me going every day. Without them life would mean nothing and I probably wouldn't do anything for myself or anyone else. I would be as good as dead. . . .
>
> To be healthy in spirit and body you need people who care about you and keep you going. . . . Otherwise life would be a sad unhealthy monotony. . . .
>
> I keep in touch with myself through other people especially my husband and daughter and they "keep me busy" and "on my toes" all the time. . . .
>
> You can't do it all for yourself. It's OK to need others. . . .

Another related way in which the support system contributed to health, especially mental health, was by ameliorating some common age-related social losses, such as loss of job, death of friends or spouse, or decreased responsibility of providing for grown children, through provision of a structure wherein social roles and expectations for the older person were continued or replaced with ones that were congruent with their desires and capabilities and at the same time entailed respect and were valued and useful to both the elderly person and his social group. By encouraging and allowing adequate role performance of these elderly, the support systems appeared to foster within them feelings of competency and satisfaction in what they could do. The following

statements illustrate ways in which roles have been maintained or favorably changed and the concurrent feelings of efficacy.

> I have always worked at home taking care of my family. I have more responsibility now than 20 years ago. Now I have a disabled husband and seven grandchildren to watch. But I'm not complaining. I can help and without me they wouldn't know what to do. . . .
>
> Since I have retired I am doing something that is very important to my people and all old people. My young Mexican friend got me involved in politics for the older people. Now I am on many committees concerned with the elderly at the local, state, and even national levels. I guess because of my experiences in life they feel I have some important things to say. . . .

Directly affecting the health care of these elderly were the ways in which members of the support system, mainly kin, acted in providing alternatives to institutional and nursing home care. Most of the informants stated an insistence on remaining in present living arrangements (their own or family members' homes) "at all costs," citing a desire for freedom and continued usefulness; a fear of hospitals and nursing homes, seeing them as places that provide a meaningless existence; and a fear of losing touch with familiar places, things, and people they love. However, it appeared that for nearly one-half (9) of the informants, health and/or economic constraints necessitated a great amount of assistance from supporters in order to survive. For the others who were not in such dire need, their supporters seemed to greatly enhance the quality of health care and protected them from events that could potentiate an institutional admission.

Though there were likely substantial sacrifices on the part of the family members, it seemed that sharing and communal arrangements

were working to keep these people at home. Female kin, most often daughters and granddaughters, played the major role in providing home care. They maintained the most contact with the older person thereby making more possible early intervention when it seemed necessary; made most of the decisions concerning health care by verifying acute illnesses and deciding when to seek assistance from professional health care providers (there was no acknowledged use of indigenous caregivers such as curanderos); provided most of the practical help with health care tasks and daily chores such as grooming, preparation of foods and home remedies, and interpretation and help in complying with medical instructions; provided most of the expressed concern and compassion for an ill or uncomfortable person as well as the verbal encouragement to "stay well;" and finally, they worked with other family members to help during emergencies, to provide money, shelter, and food, and to negotiate with the social service system (primarily welfare and Medicaid) to get what they needed for themselves and their elderly relatives.

Thus, the most active members of the informal support system in providing direct health care to these elderly are women, usually daughters, granddaughters, and sometimes goddaughters. Since they are the ones from the support system who have the major responsibility for health care matters and who likely have the most knowledge and control over many aspects of health care, it is they who could initially be integrated into nursing care and it is also they, together with nurses, who may be most effective in establishing a link between more professional health caregivers and the elderly person and additional members of his support system.

In conclusion, the well-being of these Mexican-American elderly, with repect to their support systems, seemed to be impacted by the following interrelated culturally influenced features: (1) available roles which were useful, valued, and continued as long as possible; (2) roles which entailed respect, involved responsibility, and allowed an advisory status; (3) integration in an extended or modified extended family which often served as a residential, economic, and caregiving unit; (4) value systems which emphasized the family as a source of emotional support and shared economic resources; and (5) a value system where self-identity was defined in group and family membership and individual self-reliance was not always emphasized.

These findings appear to substantiate the proposition that there is an inherent caring system based on supportive behaviors and mediated through a sociocultural network that is attempting to maintain the economic, social, and personal integrity of these elderly Mexican-Americans. Considering that these elderly are likely to be members of a highly personalized network who confine most of their social activities to kin and close friend relationships and who may be embedded and active in a family unit that can function as a barrier against physical and mental impairment and is characterized by mutual help between generations and limited use of formally organized supports, what are some implications for health care providers concerned with offering responsive, cultural consonant care?

Implications

Taking the position that professional health care services should

complement the existing support system by identifying the supports involved in health maintenance and filling the "gaps" where needs are identified and, given the likelihood that there are significant differences in patterns of support among various cultural groups, it seems essential that the elderly themselves be involved in decisions concerning their care. In this study, the informants were asked what their unmet desires from professional health care services were. Over three-fourths (16) of the informants stated a need for more home health care services delivered by nurses who could give help with medical instructions and techniques, mental health care, basic physical therapy, and most importantly, health screening before hospital admissions. They suggested that the nurses make contact with the elderly through local physicians, religious organizations, and door-to-door neighbhorhood visits as these may be the only ways to find that many needy Mexican-American elderly who will not or cannot leave their homes.

There may be many advantages to home health care if the home is adequate or can be made adequate through selected interventions. One important advantage is that many older people prefer to remain at home. Familiar surroundings are reassuring and the older person would not have to be separated from family and friends. People who may be ill or not ambulatory would not have to be forced to leave home and travel to get treatment. Earlier intervention would be more possible since it would not be necessary to wait until hospitalization to begin treatment and with home care, hospitalized patients should be able to leave the hospital sooner.

Home health services, if conducted in an informal

participant-observation manner would enable health care that could better accommodate the patient within the context of his social relationships and may offer a way that health personnel can begin to understand and include aspects of the indigenous caring system. The home setting, especially in the case of the Mexican-American elderly, would provide access to several elements within the support system. Such home visits would enable identification of the caregiving roles within the support system, promote an awareness of present (or absent) supportive behaviors and allow observation of the elderly's role activities. Home care would more readily accommodate supportive and therapeutic measures that might already be operating within the home for the older person and could enhance the caregivers' understanding of illness and health maintenance. With the event of illness and disability, life would not have to be completely disrupted; instead, the elderly person and his caregivers could remain where professional help with health care can be observed and participated in and where recovery, rehabilitation, or at least health maintenance can be seen to occur.

Many of these Mexican-American elderly have been exposed to problems such as poverty and stressful political circumstances that need to be addressed as health care issues are considered. Home visits conducted in a participant-observatory manner with the intent of learning first-hand the problems and desired reparations, would enable assessment and enhance health personnel's understanding of the life situation and environmental factors that influence their health and illness.

An attendant responsibility for health personnel is to explore

the economic resources for the elderly at home and consider the accessibility of home services for these populations. At present, in this state, home services are limited, especially for people on low incomes and those dependent on Medicare-Medicaid funding for health care. There are three agencies offering home services for those who can pay or have private insurance, and there are two agencies (Public Health Nursing and Community Nursing Services) that are certified to receive Medicare or Medicaid payments. These organizations generally provide care for short-term intervention linked to acute illness and communicable diseases and only limited intermittent care for chronic conditions. Thus, with this delivery system, it seems that the elderly who are poor and suffering chronic impairments are denied the opportunity for the kind of home services they need.

With today's growing momentum towards reduction of funding for service programs, implementation of efficient health care seems crucial. Restructuring health care for the elderly to include well-developed, less expensive home health services with adequate funding, including changes in reimbursement policies of Medicare and Medicaid would foster home health care services and discourage the use of hospital and nursing home-based services. This would offer a less expensive and more desirable alternative to institutional care and could greatly enhance the quality of life for older people and their families.

It is interesting to note, from a cross-national comparison, the trend in home health services. In the U.S., home visits are very limited compared to countries that now have government-financed and controlled health systems such as England, Norway, and the Soviet Union,

where home visiting by professionals is explicitly encouraged (Dimsdale, 1979). In developing countries such as Cuba, where there is a shortage of health professionals, nonprofessional representatives from health centers routinely make house calls to patients (Dimsdale, 1979). Perhaps, with pressure, our medical and nursing practice will begin to place more emphasis on the value of home health care as a unique opportunity to interact with patients' supportive networks.

When acute institutional care is indicated, alternatives to traditional kinds of hospital care should also be considered. One alternative could be to accommodate supportive friends or family members. Perhaps a female relative who has previously taken the responsibility of health care could accompany the patient to the facility and remain to act as a care partner with responsibilities in providing support and physical assistance to the patient; in assisting with the treatments and making observations of the patient's condition; and in learning with the patient about the health problems and implications.

There may be several benefits to such a cooperative institutional program for elderly Mexican-American (and other) populations. First, the overall cost of hospitalization might be reduced through utilization of friends and family members. Second, the care could be more personal and observation of the patient's condition more meaningful than that normally provided by professionals since the primary caregiver and observer is likely to be someone who knows and loves the patient and is very concerned about his well-being. The familiar caregivers could more readily and appropriately provide many of the usual kinds of support and in the presence of familiar caregivers the patient

may be allowed to carry on some of his expected role activities and also be able to depend on those to whom he is accustomed. Finally, upon discharge, the transition to the home may be made easier since there is increased opportunity for family members to obtain health care information and to more fully understand problems that might arise and how they can best be handled.

Home health services and an institutional program such as this offers a means whereby patients could more effectively be cared for within the context of their social relationships if services were initiated with a sensitivity to the mechanisms of the support system in ways that role activities and supportive behaviors are not disrupted or caregivers displaced by professionals. Such care could entail a position where health personnel complement the support system by negotiating the most suitable methods of participating in care, working with the people in solving problems while at the same time allowing them to decide the interventions that are in accord with their cultural values and patterns of supportive care.

An important part of caring for these Mexican-American elderly is offering care for their families and close friends and helping to maintain the networks that provide support. Since the elderly's self-identity appears to be intimately tied to group membership and support is anticipated from within the family unit, health care with such a focus may be desired and even expected. Health care with an individualistic focus may not be appreciated and may be detrimental to the established caring system where interdependence is inherent. Thus, health care provided in the home or institutional setting should be

concerned not only with the elderly patient, but also with the people associated with him, especially friends and family. For example: Is there a friend with similar health problems who could benefit from care or information gained by being included? Are there children who need immunization? Or a mother desiring prenatal care? Such problems should be addressed in addition to the services provided directly for the older patient.

If serious interpersonal and intergenerational stress is to be avoided in the face of economic pressure, and social changes that may bring a widening gap in the socioeconomic status between the young and old, the interdependence between generations should be fostered by: (1) enhancing the autonomy of the elderly through acknowledgement of their functional role contributions and assurance of adequate income and the best possible health care; and (2) by providing resources to families who care for elderly people. Money in the form of substantial tax exemptions, direct payment, or money for home renovations should be made available for families who are providing for elderly members. This could affect conditions where the elderly are not so likely to become a burden but instead, continue to hold positions as functional, contributing members of the family unit where they can be kept close and provided with personal attention. Further, such provisions may help to foster reciprocal relationships and the custom of sharing economic and social resources that may aid Mexican-Americans in the struggle with poverty, unemployment, and other social problems. Thus, though there is evidence suggesting that elderly Mexican-Americans are supported by

their children, the issue of adequate provision for these elderly is not resolved. There are many Mexican-American families who must be provided with the resources for making needed services available to older relatives.

Special consideration must be given to elderly Mexican-Americans who are not a part of a family unit. Many of these elderly are likely to be carrying with them values and unmet expectations of kin support, interdependence, and membership within a family group. They may be reluctant to form new friendship and the women especially may be uncomfortable in group activities outside of family relationships. Further, women who, for many years, had a major responsibility for their families' health and welfare and men who were accustomed to making decisions and giving advice with some authority could be experiencing a serious loss of role functioning. In addition, some may be hesitant and unskilled in pursuing governmental assistance. Thus, with displacement from the family these elderly could be very socially isolated, lacking adequate role activities and unable to get help with many problems of daily living. Health workers must take responsibility in seeking such older people and helping them to compensate for the absence of supporting families and the consequent scarcity of social contacts and material necessities. One intervention could be to develop foster family programs for these elderly. With support and supervision, foster families of the same or different cultural backgrounds, may provide an acceptable structure where these elderly could begin to form new roles and develop supportive reciprocal relationships not only for their own benefit, but also for that of the foster families.

Health workers need to recognize when social support is needed by patients and must continually think of ways to provide access to effective support systems, especially for vulnerable populations who may have deficient supports. At the same time, it seems very important that professional health personnel recognize and accommodate patients' "working" support systems. Many times, persons who are facing emotional and health problems and other difficulties, as well as "normal" but still stressful life events, need help in maintaining or re-establishing social roles. They need the opportunity to participate in reciprocal relationships, to receive love from appropriate persons, and to express themselves to someone who is familiar with their life situations. Frequently, and often most appropriately and effectively, this support comes from a person's social network. It has been demonstrated that the personal qualities of caregivers and modes of interaction with patients have as much therapeutic value for some health problems as do technological interventions such as medication (Dimsdale, 1979). Also, patients may not distinguish between the "curing" and "caring" aspects of medical care. Hence, social support in relation to health care cannot be overlooked.

As pointed out earlier, the organizational constraints of our health care system may discourage or even inhibit much support from the social network. It seems that our reliance on large-scale institutional medicine may be inhibiting factors. It is interesting to note that acceptance of the patients' support system by the health care profession seems greatest for problems that are minimally responsive to technological medical interventions. This is most noticeable where mental

health problems and rehabilitation for severe physical illness and long-term disability is concerned. It is hoped that with further social science research across several disciplines (especially sociology, anthropology, political science, nursing, and medicine), a greater emphasis, in health training and practice, on the patient within his social network can be provided.

Summary

This study of the sociocultural support systems of these Mexican-American elderly revealed a support system that has frequent interactions mainly among kin and close friends where reciprocal supportive interactions were found to consist of: (1) positive interpersonal exchanges, (2) intimacy, (3) self-care through interactions with others, (4) shared norms and experiences, (5) rituals, and (6) instrumental support. The support systems appeared to have a positive effect on health and health care in several interrelated ways, including: (1) provision of group membership and ongoing stimulating relationships that entail significant physical and social activity that could help to eliminate depression; (2) access to a structure where some useful role activities are available; (3) provision of economic and health care interventions that decrease need for institutional care; and (4) an emphasis on values reflecting interdependence and sharing of material and social resources, especially among family members across generations.

Kin relations were identified to form a dominant part of the social network. Bonds were formed through a system of mutual obligation

and a multitude of social activities and supportive behaviors. It was also identified that family members, especially female kin, have a major responsibility in health-related matters and may thus be elements of the support system that would be most readily integrated as pertinent care-givers within the professional health care system.

Collaboration between the professional health care system and the sociocultural support system was encouraged as a way to provide more effective and culturally appropriate health care. Alternative forms of health service delivery including more home health services and a co-operative institutional program, both designed to maintain and include the support system in ways that the existing support mechanisms are not interrupted, were considered. It was also suggested that the health professionals seek ways to support family structures in the Mexican-American (and other cultures) that emphasize family members as important elements within their support systems.

With cross-cultural diversity in social organization dimensions, particularly systems for recognizing kinship, political, economic, and technological characteristics, values, and socialization among age-sets, there may be significant variations and commonalities in patterns of support systems and meanings of support as well as a variety of styles of aging. Further, cross-cultural comparative studies of support systems may be useful in learning how to accommodate the needs of the elderly in this country and other parts of the world.

APPENDIX

INTERVIEW GUIDE

I. Identification Data:

Name: _____

Code Number: _____ Sex: _____ Age: _____

II. Elements Comprising the Sociocultural Network, Their Numbers and Frequency of Interaction:

1. Are you married? _____

2. Who do you usually live with?

   a. If relatives, how are they related? _____
   b. If others, how did you come to know them? _____

   _____

3. Do you have relatives not living with you that you see? _____, if yes,

   a. How are they related? _____
   b. How often do you see them? Daily ____ Weekly _____ Monthly _____ Less often_____

4. Do you know and visit some of your neighbors?

   a. How many of them? _____
   b. How often? Daily ____ Weekly ____ Monthly _____ Less Often _____

5. Do you work? _____ If yes, do you know and visit some of your co-workers? _____

6. Do you have acquaintances made through some type of religious affiliation? _____

7. Do you have other friends and acquaintances that you can tell me about? _____

   a. How did you come to know them? _____

   _____

   b. How often do you see them? _____

8. Can you tell me about any group "get togethers" or gatherings that you participate in within your family, neighborhood, church, or community? _____

   _____

9. Who do you go to for health care? Can you tell me about some of your experiences in getting health care? Who provides you with most of your health care information? [Probe for matters related to both professional and indigenous health caregivers.] If you were to go to a clinic or hospital run by doctors and nurses, who, from among your family and friends, would accompany you and who would you want involved in your care? _____

_____

10. Can you describe a typical day for you? [Probe for special contacts made during the day to determine who they are and number and frequency as well as the nature and content of the interactions.] _____

_____

_____

11. Who do you spend your "spare time" with? _____

_____

12. What do you do for fun and recreation and who do you do these things with? _____

_____

13. How do you celebrate holidays and saints' days? [Probe for who these times are spent with.] _____

_____

14. Do you go to weddings, wakes, funerals, or christenings? Who usually joins you in these gatherings? _____

_____

15. Will you recount for me some of your activities during the past week and who you have visited and spent time with? _____

_____

_____

16. Who do you spend time with most often (rank)?
____ brothers and sisters
____ cousins
____ sons
____ daughters
____ other relatives such as _____
____ friends
____ others such as _____

III. Supportive Interactions:

1. Who, from among these people you have told me about, do you feel greatly cared for by? That is, who respects you, is concerned for you, and makes you feel good? Who among these people can you count on for anything? And who, in turn, do you care for and who relies on you for help? _____

_____

_____

2. If you became suddenly ill, who would you contact first? Who helps you out when you're generally not feeling well? Who helps you stay well, and what kinds of things do they do for you? _____

_____

_____

3. If you were in need of money or other goods, whose help would you seek? _____

4. Who helps you with everyday things such as shopping for food, transportation around town, chores and repairs around the house, and so forth? _____

5. When you have things on your mind that trouble you, who, if anyone, can you confide in? _____

6. Who are your "closest" companions that seem to "see the world" in the same ways that you do? _____

_____

7. How do people let you know that they "care" about you and what kinds of things other than those that we've talked about do they do to help you out? _____

_____

_____

_____

_____

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